

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08035

CERTIFICATE OF DEATH

08030

Reg. Dist. No.

352

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bishopville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen R. Bishop				4. DATE OF DEATH July 5 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 16, 1885	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Bishop				14. MOTHER'S MAIDEN NAME Carrie King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. XXX		17. INFORMANT Address Miss Lizzie Bishop Bishopville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to 420.0 DUE TO coronary thrombosis (or ventricular fibrillation) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerotic heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular instability							INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 1953 to July 1957, that I last saw the deceased alive on July 1957, and that death occurred at 10:30 P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Carl B. McFadden, M.D. Selbyville, Del.							
PHYSICIAN'S NAME (Type) EARL B. McFADDEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/57		22c. NAME OF CEMETERY OR CREMATORY LOOF		22d. LOCATION (City, town, or county) (State) Bishopville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville Del.				24a. REC'D BY REGISTRAR DATE JUL 10 1957		24b. REGISTRAR'S SIGNATUREelda H. Berger	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08031

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>			c. LENGTH OF STAY IN Td <b>3 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>442 Pocomoke City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Front Street</b>				d. STREET ADDRESS <b>Front Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>H.</b> Middle <b>Clarke</b> Last <b>Bratten</b>				4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1887</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Bratten</b>				14. MOTHER'S MAIDEN NAME <b>Minnie P. Stevenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT Address <b>J.C. Stevenson, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X Acute Heart Failure</b> DUE TO <b>Protracted Asthmatic attacks</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Protracted Asthmatic attacks</b> (c) <b>Protracted Asthmatic attacks</b> DUE TO <b>Protracted Asthmatic attacks</b> (a) <b>Protracted Asthmatic attacks</b> (b) <b>Protracted Asthmatic attacks</b> (c) <b>Protracted Asthmatic attacks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Weakness after Surgery on Gallbladder</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>General Weakness after Surgery on Gallbladder</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>0</b> p. m. <b>0</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Pocomoke City, Maryland</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>N. E. Sartorius</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>N. E. Sartorius Sr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem M.E. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Anne White</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

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JUL 29 1957  
BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08032

353

08036

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near St. Martins	c. LENGTH OF STAY IN 1b Accident	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXXXX		d. STREET ADDRESS RFD	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard Alton Cathell		4. DATE OF DEATH Month July Day 26 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1939
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ice Plant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Cathell	
14. MOTHER'S MAIDEN NAME Christeen Holland		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> (If yes, give year or dates of service) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. 215-36-0689		17. INFORMANT Chas. Cathell Whaleyville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816x Fracture of Skull, Cont + Compression of DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chest & acute Pulmonary Edema etc DUE TO (c) accident		INTERVAL BETWEEN ONSET AND DEATH 5 to 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) accident ran into back, Fract	
20c. TIME OF INJURY Month, Day, Year 7 a. m. 7/26 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. High. & 50 St. Martin Worcester Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Herman A. Robbins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HERMAN A. Robbins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29 57	
22c. NAME OF CEMETERY OR CREMATORY I O O F		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville Del		24a. REC'D BY REGISTRAR DATE 30 1957	
24b. REGISTRAR'S SIGNATURE Hilda R. Briggs			



RECEIVED

JUL 30 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08032

## CERTIFICATE OF DEATH

Reg. Dist. No. 08033 350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City 42</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>714 5th. Street</b>				d. STREET ADDRESS <b>714 5th 1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Sidney</b> Last <b>Collins</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27 1882</b>		9. AGE (In years last birthday) <b>68 7/4</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergymen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Minister</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.U.S.A.</b>	
13. FATHER'S NAME <b>James Collins</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Gale</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Estella Collins, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Hypertensive Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>2 1/2 yr</b> <b>3 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7-13-</b> 19 <b>55</b> , to <b>7-18-</b> 19 <b>57</b> , that I last saw the deceased alive on <b>7/18/57</b> , and that death occurred at <b>11:25</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>801 4th St, Pocomoke Md</b> DATE SIGNED <b>7/18/57</b>							
ACTUAL SIGNATURE <b>Cecil A. Dwyer M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Cecil A. Dwyer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Halls Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton New Church, Va.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Anne White</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 26 JUL

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08034353									
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near St Martins			c. LENGTH OF STAY IN 1b Accident		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Whaleyville, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXXXX					d. STREET ADDRESS / RFD			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Davis					4. DATE OF DEATH Month July Day 26 Year 19 57				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1881		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephram Davis					14. MOTHER'S MAIDEN NAME Jane (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX			16. SOCIAL SECURITY NO. (If yes, give year or dates of service) XXX 215-26-5075		17. INFORMANT Annie Davis Address Whaleyville, Md. RFD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to Fracture of Skull, Fracture of Mandible Instantly 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cervical Spine, large laceration & puncture DUE TO (c) Wound of Thoracic Compression of Chest PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accident - Automobile 20c. TIME OF INJURY Month, Day, Year 7/26 1957 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Highway 56 St. Martins Worcester, Md. 20f. (City or town) (County) (State) St. Martins Worcester, Md. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> MEDICAL CERTIFICATION 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/28/57 22c. NAME OF CEMETERY OR CREMATORY Pulletts Chapel 22d. LOCATION (City, town, or county) (State) Whaleyville, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Whaleyville, Md. 24a. REC'D BY REGISTRAR JUL 30 1957 24b. REGISTRAR'S SIGNATURE Heldert K. Berger									

BUREAU V. E.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08038

CERTIFICATE OF DEATH

08035

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
c. LENGTH OF STAY IN 1b <u>57 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 22 - 1876</u>	
9. AGE (In years, months, days, hours, minutes) <u>81</u> years <u>4</u> months <u>18</u> days <u>18</u> hours <u>18</u> minutes		10. AGE (In years, months, days, hours, minutes) <u>81</u> years <u>4</u> months <u>18</u> days <u>18</u> hours <u>18</u> minutes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gaylord L. Warren</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Cropper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Wm E. Davis, Newark, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443 X</u> <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>55</u> , to <u>7/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>57</u> , and that death occurred at <u>1:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, MD 512 E. Market St. Snow Hill, Md</u>		DATE SIGNED <u>7/15/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newark Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Jones</u>		24a. REC'D BY REGISTRAR <u>July 10 1957</u>	
ADDRESS <u>Snow Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Elmer E. Jones</u>	

## MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JUL 10 1957

RECEIVED

08039

## CERTIFICATE OF DEATH

08036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>1</u> <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>DORA FLORENCE DENNIS</u>		4. DATE OF DEATH <u>July 16</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 27, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SMACK</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH KELLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR. WALTER DENNIS</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>static pneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 mos.</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2601 atherosclerosis and diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 13</u> , 19 <u>57</u> , to <u>July 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb</u> M.D.		ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u>	
DATE SIGNED <u>7-16-57</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>7/17/57</u>	<u>7/17/57</u>	<u>RIVERSIDE</u>	<u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>WILL 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Kelen Hayward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form No. 10

BUREAU V. 3

JUL 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08037  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>WOR</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>		c. LENGTH OF STAY IN 1b <b>33 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>306 Somerset St</b>				d. STREET ADDRESS <b>306 Somerset St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GARDNER Willis DENNIS</b>				4. DATE OF DEATH Month Day Year <b>July 16 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1920</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transport</b>		11. BIRTHPLACE (State or foreign country) <b>Berlin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pitts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Robbins, Mother, 306 Somerset Ocean City, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-Vascular Accident (NON TRAUMATIC)</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>331X</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Francis J. Townsend Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>July 16, 57</b>	
EXAMINER'S NAME (Type) <b>FRANCIS J. TOWNSEND JR.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart</b>				ADDRESS <b>Funeral Home, Salisbury, Md</b>		24a. REC'D BY REGISTRAR <b>John F. Hayward</b>	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 19 1957

RECEIVED

08041

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WILMINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHALEYVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 WHALEYVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY EDWARD DOWNING</u>				4. DATE OF DEATH Month Day Year <u>JULY 6 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 34, 1915</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE BLDG-</u>		11. BIRTHPLACE (State or foreign country) <u>MARIONSVILLE, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILMER DOWNING</u>				14. MOTHER'S MAIDEN NAME <u>SARAH FLETCHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WARD 4-116</u>		17. INFORMANT Address <u>MRS. PAUL STEPHENSON BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 hour</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> <u>alcoholism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 6, 1957</u> to <u>July 6, 1957</u> , that I last saw the deceased alive on <u>July 6, 1957</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u> DATE SIGNED <u>7-8-57</u>							
ACTUAL SIGNATURE <u>Robert H. Grubb</u> M.D.				PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HEBRON</u>		22d. LOCATION (City, town, or county) (State) <u>HEBRON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Hayward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED

DATE OF DEATH  
PLACE HERE

DATE OF BIRTH

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BUREAU V. 3

JUL 11 1957

RECEIVED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG218 7-22-57 et

## CERTIFICATE OF DEATH

08042

08039

Reg. Dist. No. 310

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #2 Box 310</u>				STREET ADDRESS (If rural give location) <u>RFD #2 Box 310</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rose ANNA</u> (Middle) <u>Ewell</u> (Last)				(Month) <u>July</u> (Day) <u>5</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 27 1888</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Handy</u>				14. MOTHER'S MAIDEN NAME <u>Annie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-0510</u>		17. INFORMANT & ADDRESS <u>John James Ewell</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>						<u>4 dys.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Essential Hypertension</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>(a) Dehydration (b) Exhaustion</u>						<u>1 wk.</u>	
19a. DATE OF OPERATION <u>4/4/57</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/9/57</u> , 19 <u>57</u> , to <u>July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Beard A. Duweney</u> M.D.				ADDRESS (Street, city, town, state) <u>Pocomoke City, Md.</u>			
DATE SIGNED <u>7/5/57</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/8/57</u>		NAME OF CEMETERY OR CREMATORY <u>WATTSVILLE Cem.</u>		LOCATION (City, town, or county) (State) <u>WATTSVILLE, VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Donc White</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, VA.</u>		ADDRESS	
DATE <u>JUL 16 1957</u>							

# CERTIFICATE OF DEATH

Use Only No. 1

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. MEDICAL CERTIFICATION

10. DATE OF DEATH

11. TIME OF DEATH

12. PLACE OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWN CLERK

24. SIGNATURE OF VILLAGE CLERK

25. SIGNATURE OF POSTMASTER

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF CORONER

BUREAU V. 4

JUL 16 1957

RECEIVED

08043

CERTIFICATE OF DEATH

08040 3J

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY 21122</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>213 DAVIS ST</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GOLDIG EDITH GRIFFIN</b>				4. DATE OF DEATH <b>JULY 29 1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 29, 1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM HUDSON</b>				14. MOTHER'S MAIDEN NAME <b>ROSINA McCABE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>MR. C. H. GRIFFIN</b> Address <b>SALISBURY MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Liver &amp; Secondary</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Colic &amp; Brachytherapy</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 15, 1957</b> , to <b>July 26, 1957</b> , that I last saw the deceased alive on <b>21 July 1957</b> , and that death occurred at <b>P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herman A. Robbins</b> M.D.				DATE SIGNED <b>Berlin, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Herman A. Robbins M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/1/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna H. Burbage</b> ADDRESS <b>Berlin Md.</b>				24. RECD BY REGISTRAR <b>ALG 5</b> DATE <b>1957</b>			
25. REGISTRAR'S SIGNATURE <b>Robert F. Hayward</b>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF SURVIVOR		22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF FUNERAL HOME		26. SIGNATURE OF CEMETERY		27. SIGNATURE OF CHURCH		28. SIGNATURE OF MONASTERY		29. SIGNATURE OF HOSPITAL		30. SIGNATURE OF NURSING HOME	
31. SIGNATURE OF PRISON		32. SIGNATURE OF ASYLUM		33. SIGNATURE OF MENTAL HOSPITAL		34. SIGNATURE OF TUBERCULAR HOSPITAL		35. SIGNATURE OF LEPROSY HOSPITAL		36. SIGNATURE OF OTHER HOSPITAL	
37. SIGNATURE OF OTHER INSTITUTION		38. SIGNATURE OF OTHER PLACE		39. SIGNATURE OF OTHER BUILDING		40. SIGNATURE OF OTHER STRUCTURE		41. SIGNATURE OF OTHER ENCLOSURE		42. SIGNATURE OF OTHER FENCE	
43. SIGNATURE OF OTHER BARRIER		44. SIGNATURE OF OTHER OBSTACLE		45. SIGNATURE OF OTHER HAZARD		46. SIGNATURE OF OTHER DANGER		47. SIGNATURE OF OTHER THREAT		48. SIGNATURE OF OTHER PERIL	
49. SIGNATURE OF OTHER HARM		50. SIGNATURE OF OTHER DAMAGE		51. SIGNATURE OF OTHER LOSS		52. SIGNATURE OF OTHER INJURY		53. SIGNATURE OF OTHER HURT		54. SIGNATURE OF OTHER PAIN	
55. SIGNATURE OF OTHER SUFFERING		56. SIGNATURE OF OTHER GRIEF		57. SIGNATURE OF OTHER ANGER		58. SIGNATURE OF OTHER FEAR		59. SIGNATURE OF OTHER SHAME		60. SIGNATURE OF OTHER DISGRACE	
61. SIGNATURE OF OTHER REPROACH		62. SIGNATURE OF OTHER CONTEMPT		63. SIGNATURE OF OTHER SCORN		64. SIGNATURE OF OTHER DERISION		65. SIGNATURE OF OTHER RIDICULE		66. SIGNATURE OF OTHER MOCKERY	
67. SIGNATURE OF OTHER JEER		68. SIGNATURE OF OTHER TRIFLE		69. SIGNATURE OF OTHER TRIVIAL		70. SIGNATURE OF OTHER INSIGNIFICANT		71. SIGNATURE OF OTHER UNIMPORTANT		72. SIGNATURE OF OTHER UNCONSIDERABLE	
73. SIGNATURE OF OTHER INCONSIDERABLE		74. SIGNATURE OF OTHER INAPPRECIABLE		75. SIGNATURE OF OTHER INESTIMABLE		76. SIGNATURE OF OTHER INCALCULABLE		77. SIGNATURE OF OTHER UNMEASURABLE		78. SIGNATURE OF OTHER UNLIMITED	
79. SIGNATURE OF OTHER INFINITE		80. SIGNATURE OF OTHER ENDLESS		81. SIGNATURE OF OTHER INTERMINABLE		82. SIGNATURE OF OTHER UNENDING		83. SIGNATURE OF OTHER UNCEASING		84. SIGNATURE OF OTHER UNINTERMITTING	
85. SIGNATURE OF OTHER UNINTERMITTING		86. SIGNATURE OF OTHER UNINTERMITTING		87. SIGNATURE OF OTHER UNINTERMITTING		88. SIGNATURE OF OTHER UNINTERMITTING		89. SIGNATURE OF OTHER UNINTERMITTING		90. SIGNATURE OF OTHER UNINTERMITTING	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08041 351**

1. PLACE OF DEATH o. COUNTY <b>WORCESTER</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SNOW HILL</b>		c. LENGTH OF STAY IN 1b <b>7 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SNOW HILL x 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>108 FRANKLIN ST</b>		
3. NAME OF DECEASED (Type or print) <b>RALPH LEVIN HALL</b>			4. DATE OF DEATH <b>JULY 3 1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jul 20 - 1944</b>	9. AGE (In years last birthday) <b>13 4/5</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOLBOY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>✓</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA Appalachia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>HARRY HALL</b>			14. MOTHER'S MAIDEN NAME <b>Alice Kelly</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>HARRY HALL</b>		Address <b>SNOW HILL MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACCIDENTAL DROWNING</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>DROWNED WHILE BATHING IN IRRIGATION POND ON A FARM</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:45 p.m. July 3 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>farm</b>	20f. (City or town) (County) (State) <b>Snow hill, Worc Md,</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Robert C. La Mar</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7-4-57</b>
EXAMINER'S NAME (Type) <b>ROBERT C. LA MAR, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial July 3/57</b>		<b>Restlawn Cemetery</b>		<b>Snow Hill, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne E. Sumner</b>		ADDRESS <b>Snow Hill, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Shirley Cooper</b>	
		24a. REC'D BY REGISTRAR <b>JUL 8 1957</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal, file pages 1 and 2 with the registrar.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>8 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>OCEAN CITY BLVD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA MAG JARMON</u>				4. DATE OF DEATH Month Day Year <u>JULY 4 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1876</u>		9. AGE (In years lost birthday) yrs. <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM L HUDSON</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. WILLIAM JARMON BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete intestinal obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Probable CARCINOMA of COLON</u> ? DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>578X CHRONIC INTESTINAL HEMORRAGHE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCTOBER, 1954</u> to <u>JULY 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 4</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u> DATE SIGNED <u>7-5-57</u> ACTUAL SIGNATURE <u>Robert A. Grubb</u> M.D. PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Anna P. Barbours Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Kenn. P. Hayward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 2

JUL 9 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08033

CERTIFICATE OF DEATH

08043

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>45 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Front Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Hundley</b> Last <b>Mariner</b>				4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 18, 1880</b>	
9. AGE (In years lost birthday) yrs. <b>77</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Wheelwright and Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Oliver James Mariner</b>			
14. MOTHER'S MAIDEN NAME <b>Amanda Ailsworth</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>220-16-9688</b>				17. INFORMANT <b>Jermond Lee Mariner, Pocomoke, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Odema</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> (c) <b>Cerebral Arteriosclerosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b> <b>3 months</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>612x</b> <b>Prostate removed</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> , 19 <b>57</b> , to <b>July 7</b> , 19 <b>57</b> that I last saw the deceased alive on <b>July 2th</b> , 19 <b>57</b> , and that death occurred at <b>6 M</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>J. E. Sartorius Sr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>N. E. Sartorius Sr.</b>				<b>Pocomoke City, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Anne White</b>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08044

08046

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Berlin</u>		LENGTH OF STAY (In this place) <u>12 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Railway Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u>		(Middle)		(Last) <u>May</u>		(Month) (Day) (Year) <u>July 24, 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>February 1883</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Raleigh, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Moses Jeffries</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Ethel Buddell - Berlin</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-4-57</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-16</u> , 19 <u>53</u> , to <u>7-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-22</u> , 19 <u>57</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry U. Sively, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Berlin, Md</u>		DATE SIGNED <u>7/24/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-27-57</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen in Care</u>		LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Allen H. Hayward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooke M. Walsh</u>		ADDRESS	
DATE <u>AUG 1 1957</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08045

08047

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural #3 Box 35</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural #3 Box 35</u>	
c. LENGTH OF STAY IN 1b <u>48 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Parker</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 - 1875</u>
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 MRS. last birthday) <u>81</u> yrs. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTH PLACE (State or foreign country) <u>Pittsville MD</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles Parker</u>	
14. MOTHER'S MAIDEN NAME <u>Millie Simmons</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mary Parker Berlin MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) <u>Stroke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>27 days</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/16</u> , 19 <u>56</u> , to <u>6/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>57</u> , and that death occurred at <u>2:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stacy U. Shuler Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin MD</u>	
DATE SIGNED <u>7/1/57</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Rural #3 Box 35 MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Thomas</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>7/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wileen Hayward</u>	

# CERTIFICATE OF DEATH

BUREAU V. 3

JUL 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08046

08048

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin(Rural)</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B.D.# (Route 276) Libertytown Rd</b>		MARYLAND c. LENGTH OF STAY IN 1b  d. STREET ADDRESS <b>204 Record St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 22122	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>RAY</b> Last <b>PARKS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1927</b>	9. AGE (In years last birthday) <b>29</b> yrs.	IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Salesman(Koester Bakery Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tangier Island, Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
13. FATHER'S NAME <b>Wesley Parks</b>		14. MOTHER'S MAIDEN NAME <b>Etta Parks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Alberta Ruth Parks (Wife)</b> <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Schrock act. C.F. 9 skull &amp; base of Brain</b> 823x DUE TO <b>+ exposure, + head fall, +</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Fr. S. L. Roberts &amp; Ulna, Rt Ferner, L. Clavich</b> DUE TO <b>Fr. 7-8 Ribs Rt., Compression, Rt side &amp; base</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran into an abutment on Rt 276 Md.</b>			
20c. TIME OF INJURY Month, Day, Year <b>8<sup>th</sup> a.m. 7/22/1957</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 276 Highway</b>	20f. (City or town) <b>Berlin (Libertytown)</b>	(County) <b>Worcester</b>	(State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Herman A. Robbins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/22/57</b>	
EXAMINER'S NAME (Type) <b>Dr. Herman A. Robbins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 25, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Swain Meth. Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Tangier Island, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>24a. REC'D BY REGISTRAR</b>		24b. REGISTRAR'S SIGNATURE <b>Helen F. Hayward</b>	

JUL 25 1957



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Place of Issue		Official Seal	

**RECEIVED**  
JUL 25 1957  
BUREAU OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08049

## CERTIFICATE OF DEATH

08048 351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiddletown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiddletown</u>	
c. LENGTH OF STAY IN 1b <u>6.3 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>W.</u> Last <u>Redden</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13-1894</u>
9. AGE (In years last birthday) <u>63 1/4</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Shiddletown, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George W. Redden</u>		14. MOTHER'S MAIDEN NAME <u>Ella Sanford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mrs Rosa H. Redden</u>		Address <u>Shiddletown, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Myocarditis</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>7/14/57</u> , 19____, that I last saw the deceased alive on <u>7/11/57</u> , 19____, and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Shiddletown, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Simms</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Elwyn Casper</u>	
DATE <u>16 1957</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
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76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
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94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED  
JUL 16 1957  
BUREAU V. R.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08049 355

08050

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>YORK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. LENGTH OF STAY IN lb <u>5 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beach At Dorchester St</u>				d. STREET ADDRESS <u>1026 W. KING</u>			
3. NAME OF DECEASED (Type or print) <u>Russell Gerald Reider</u>				4. DATE OF DEATH <u>July 25</u> 19 <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 19, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATTERN MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>			
11. BIRTHPLACE (State or foreign country) <u>YORK, PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Reider</u>				14. MOTHER'S MAIDEN NAME <u>FANNY Shue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>1026 W KING</u>			
17. INFORMANT <u>MRS Lyla Reider (wife)</u>				Address <u>YORK, PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion Acute</u> <u>420.1</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 months</u> DUE TO <u>5 years</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>July 25, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>YORK PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Gurbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE 29 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Walter H. Hayward</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUL 29 1957  
BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08050

Reg. Dist. No.

355

08051

Item 9 Film 218 7-30-57 et

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 BERLIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BRUCE</b> Middle <b>LEON</b> Last <b>SPENCE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>(78) yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAY WORK</b>	
11. BIRTHPLACE (State or foreign country) <b>NEWARK, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH SPENCE</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA COLLINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>DOLLIE SHOCKLEY</b>		Address <b>BERLIN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, due Multiple Fracture</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>+ Confusions, c F.C.C. Skull + Lac. of Brain</b> DUE TO (c) <b>F.C.C. Ro Tibia + Fibula, F.S. Rt clavicle + Internal Organs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by car Truck while riding a bicycle</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:30 a.m. 7/19/ 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 113 -</b>		20f. (City or town) (County) (State) <b>Berlin, Worcester Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Herman A. Robbin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>HERMAN A. Robbin S. MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/22/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR CHAPEL</b>		22d. LOCATION (City, town, or county) (State) <b>NEWARK MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna H. Burboye</b>		ADDRESS <b>Berlin Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 7/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>Robert F. Hayward</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Minister of the Gospel	
22. Signature of Minister of the Word		23. Signature of Minister of the Sacrament		24. Signature of Minister of the Eucharist	
25. Signature of Minister of the Holy Communion		26. Signature of Minister of the Holy Eucharist		27. Signature of Minister of the Holy Sacrament	
28. Signature of Minister of the Holy Eucharist		29. Signature of Minister of the Holy Sacrament		30. Signature of Minister of the Holy Eucharist	
31. Signature of Minister of the Holy Sacrament		32. Signature of Minister of the Holy Eucharist		33. Signature of Minister of the Holy Sacrament	
34. Signature of Minister of the Holy Eucharist		35. Signature of Minister of the Holy Sacrament		36. Signature of Minister of the Holy Eucharist	
37. Signature of Minister of the Holy Sacrament		38. Signature of Minister of the Holy Eucharist		39. Signature of Minister of the Holy Sacrament	
40. Signature of Minister of the Holy Eucharist		41. Signature of Minister of the Holy Sacrament		42. Signature of Minister of the Holy Eucharist	
43. Signature of Minister of the Holy Sacrament		44. Signature of Minister of the Holy Eucharist		45. Signature of Minister of the Holy Sacrament	
46. Signature of Minister of the Holy Eucharist		47. Signature of Minister of the Holy Sacrament		48. Signature of Minister of the Holy Eucharist	
49. Signature of Minister of the Holy Sacrament		50. Signature of Minister of the Holy Eucharist		51. Signature of Minister of the Holy Sacrament	
52. Signature of Minister of the Holy Eucharist		53. Signature of Minister of the Holy Sacrament		54. Signature of Minister of the Holy Eucharist	
55. Signature of Minister of the Holy Sacrament		56. Signature of Minister of the Holy Eucharist		57. Signature of Minister of the Holy Sacrament	
58. Signature of Minister of the Holy Eucharist		59. Signature of Minister of the Holy Sacrament		60. Signature of Minister of the Holy Eucharist	
61. Signature of Minister of the Holy Sacrament		62. Signature of Minister of the Holy Eucharist		63. Signature of Minister of the Holy Sacrament	
64. Signature of Minister of the Holy Eucharist		65. Signature of Minister of the Holy Sacrament		66. Signature of Minister of the Holy Eucharist	
67. Signature of Minister of the Holy Sacrament		68. Signature of Minister of the Holy Eucharist		69. Signature of Minister of the Holy Sacrament	
70. Signature of Minister of the Holy Eucharist		71. Signature of Minister of the Holy Sacrament		72. Signature of Minister of the Holy Eucharist	
73. Signature of Minister of the Holy Sacrament		74. Signature of Minister of the Holy Eucharist		75. Signature of Minister of the Holy Sacrament	
76. Signature of Minister of the Holy Eucharist		77. Signature of Minister of the Holy Sacrament		78. Signature of Minister of the Holy Eucharist	
79. Signature of Minister of the Holy Sacrament		80. Signature of Minister of the Holy Eucharist		81. Signature of Minister of the Holy Sacrament	
82. Signature of Minister of the Holy Eucharist		83. Signature of Minister of the Holy Sacrament		84. Signature of Minister of the Holy Eucharist	
85. Signature of Minister of the Holy Sacrament		86. Signature of Minister of the Holy Eucharist		87. Signature of Minister of the Holy Sacrament	
88. Signature of Minister of the Holy Eucharist		89. Signature of Minister of the Holy Sacrament		90. Signature of Minister of the Holy Eucharist	
91. Signature of Minister of the Holy Sacrament		92. Signature of Minister of the Holy Eucharist		93. Signature of Minister of the Holy Sacrament	
94. Signature of Minister of the Holy Eucharist		95. Signature of Minister of the Holy Sacrament		96. Signature of Minister of the Holy Eucharist	
97. Signature of Minister of the Holy Sacrament		98. Signature of Minister of the Holy Eucharist		99. Signature of Minister of the Holy Sacrament	
100. Signature of Minister of the Holy Eucharist		101. Signature of Minister of the Holy Sacrament		102. Signature of Minister of the Holy Eucharist	

**RECEIVED**  
JUL 25 1957  
BUREAU V. 2

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08051

08052

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark, md.</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Newark</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Honolulu Long Trader</u>				4. DATE OF DEATH <u>July 5 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Selbyville, Del.</u>	
13. FATHER'S NAME <u>Zena P. Long</u>				14. MOTHER'S MAIDEN NAME <u>Patience McCabe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Maggie J. Trader Jackson</u>				Address <u>Newark md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/5</u> , 1957, to <u>7/5</u> , 1957, that I last saw the deceased alive on <u>7/5</u> , 1957, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>Newark, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones</u>				DATE SIGNED <u>7/5/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 7<sup>th</sup> 1957</u>		<u>Bowen</u>		<u>Newark md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>JUL 8 1957</u>				<u>Allyn Cooper</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

MARYLAND

BUREAU V. 5

JUL 8 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08053

CERTIFICATE OF DEATH

08052353  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXX</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter J. Warren</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30 1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sheet Metal worker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Josiah Warren</b>				14. MOTHER'S MAIDEN NAME <b>Olevia Rayne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>World War # 1</b>		16. SOCIAL SECURITY NO. <b>218-20-7377</b>		17. INFORMANT Address <b>Clarence Warren Bishopville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension - arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> , 19 <b>7-6-57</b> , to <b>7-6-57</b> , that I last saw the deceased alive on <b>7-6-57</b> at <b>2:15 A.M.</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Lewis</b>				ADDRESS (Street, city or town, state) <b>Willards Maryland</b>			
PHYSICIAN'S NAME (Type) <b>FRANK Lewis M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>1100 F</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Whaley</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Hilda R. Berger</b>	



JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08034

## CERTIFICATE OF DEATH

08053

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>42</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>506 Laura</b>		d. STREET ADDRESS <b>506 Laura</b>	
3. NAME OF DECEASED (Type or print) <b>George</b> First <b>T. Williams</b> Middle <b>Lost</b>		4. DATE OF DEATH <b>July</b> Month <b>20</b> Day <b>1957</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saw Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Timber</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Martha Downing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>191-16-9073</b>	
17. INFORMANT <b>Maggie Williams</b>		Address <b>Stockton, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Acute Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Constrictive Heart Failure</b> DUE TO lying cause lost. (c) <b>Hypertensive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>18 mths</b> <b>18 mths</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>502.1 Chronic Bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/1/56</b> to <b>7/20/57</b> , that I last saw the deceased alive on <b>7/20/57</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Beal A. Stoverney</b>		ADDRESS (Street, city or town, state) <b>801-4 St, Pocomoke</b> DATE SIGNED <b>7/28/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wattsville, Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Wattsville, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton</b>		ADDRESS <b>New Church, Va.</b>	
24a. REC'D BY REGISTRAR <b>JUL 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Anne Thibault</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 1

JUL 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08054351  
Reg. Dist. No.

08054

1. PLACE OF DEATH o. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SNOW HILL</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Worc.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b> <b>X2</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WRIGHT</b> Last <b>WRIGHT</b>			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1957</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Poland</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 27-1930</b>		9. AGE (In years last birthday) <b>27-2-29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Snow Hill Canning Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Snow Hill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>			
13. FATHER'S NAME <b>JAMES WRIGHT</b>				14. MOTHER'S MAIDEN NAME <b>NANCY POWELL</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>207-20-16a3</b>		17. INFORMANT Address <b>Wilsie Townsend Snow Hill, Md. Rural #1</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Heart</b> <b>981x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bullet wound</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possibly had been drinking alcoholic beverages</b>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Robert C. La Mar</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>7-20-57</b>	
EXAMINER'S NAME (Type) <b>ROBERT C. LA MAR, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>July 23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Snow Hill, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clayton G. Ginn</b>				ADDRESS <b>Snow Hill, Md</b>		24a. REC'D BY REGISTRAR <b>DATE 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Clayton G. Ginn</b>	

BUREAU V. 8

JUL 23 1957

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